

**INITIAL HEALTH STATUS**

**CARING RELIEF FOR:**  
*Headaches  
Back and neck pain  
Shoulder and arm pain  
Knee and leg pain  
Whiplash*



**FOR YOUR COMFORT AND CONVENIENCE**  
*Available weekends  
Same-day appointments  
Insurance accepted and filed  
Flexible payment plans  
Major credit cards accepted*

**RESSLER CHIROPRACTIC INC.**

*Where your relief is our first concern, but your health is our primary purpose.*

Name \_\_\_\_\_  Male  Female Home Phone \_\_\_\_\_

Address (No P.O. Box) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

The below box is our primary means of communication, please complete as legibly as possible.

Email Address _____	Cell Phone _____
	Carrier/Provider (att, sprint, Verizon...) _____

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital: M S How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Parents (if under 18 yrs.) \_\_\_\_\_

Benefits desired from seeking care in our office (check all that apply):  
 Maintenance or Supportive Care  
 Correction of Your Condition  
 Pain Relief

Chief complaint(s):  Neck  Upper back  Mid back  Low back  
 Shoulder/arm  Hip/leg  Headaches  Other \_\_\_\_\_

Date problem began \_\_\_\_\_

Other doctors seen for this condition \_\_\_\_\_

Is this condition due to a:  Work injury?  Auto accident?  Slip and fall?  N/A

How problem began \_\_\_\_\_

**Financial Responsibility**

- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.
- I further understand that Ressler Chiropractic Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Ressler Chiropractic Inc. will be credited to my account upon receipt.
- I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.
- I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

What is your chief reason for being here? \_\_\_\_\_

If there is a specific condition; how long has it been occurring? \_\_\_\_\_

Do you have any relatives with similar problems?  No  Yes, Who? \_\_\_\_\_

List any practitioners seen for this condition: \_\_\_\_\_

Have you had similar problems before? \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  No  Yes

If yes, describe: \_\_\_\_\_

List diagnosis and type of treatments so far: \_\_\_\_\_

What do you feel is causing any health problems you may have? \_\_\_\_\_

Please indicate **any** occurrence of the following and give details and dates:

Accidents/injuries: \_\_\_\_\_

Fractures: \_\_\_\_\_

Hospitalizations/Surgeries : \_\_\_\_\_

Have you lost any days of work recently?  No  Yes Dates: \_\_\_\_\_

What is your Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_ (last reading)

Current complaint (how you feel today): 0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain

How often are your symptoms present?  
(Occasional)  10 - 25%  26-50%  51-75%  76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

0 1 2 3 4 5 6 7 8 9 10  
No interference Can't Do Anything

Please check all of the following that apply to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Prostate Problems                        |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Menstrual Problems                       |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Urinary Problems                         |
| <input type="checkbox"/> Heart Attack                                     | <input type="checkbox"/> Currently Pregnant, # weeks _____        |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Abnormal Weight Gain or Loss             |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness            |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain Unrelieved by Position or Rest      |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at Night                            |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances                      |
| <input type="checkbox"/> Cancer/Tumor                                     | <input type="checkbox"/> Surgeries                                |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Medications (list to right)              |
| <input type="checkbox"/> Epilepsy/Seizures                                | <input type="checkbox"/> Other Health Problems (explain to right) |

Family History:

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems/Stroke |   |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_